

Provider Enrollment Form**U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs**OMB Number 1215-0137
Expires: 03/31/2007**Please refer to instructions for completing this form.**

Provider Number	Effective Date
FOR DOL USE ONLY	

1. Are you applying for a new enrollment or updating your record?
If update, enter Provider Number or EIN: ☐ New enrollment ☐ Update
2. What is the earliest date that you treated a participant in any OWCP program?

Practice Information

3. Practice Name	4. Address		
5. City	6. State	7. Zip (9 digits)	
8. Telephone	9. FAX		
10. Type of Practice a. <input type="checkbox"/> Individual b. <input type="checkbox"/> Facility (For Individual or Facility, complete indicated sections below) c. <input type="checkbox"/> Group (Please see reverse for completion of group enrollment)			

Provider Type (Individual or Facility)

11a. Provider Type Code	11b. Provider Type
11c. If you select "Other Provider" (96) or Non-Medical Vendor (53), please explain:	
12. Tax ID: EIN	SSN
13. Medicare Number (required for hospitals only)	

License and Certification (Individual for M.D. and D.O. only)

14a. Name	14b. License #/ State	14c. Current Lic Expiration Date	14d. Specialty Code(s)	14e. Certification Expiration Date

15. UMWA Health & Retirement Funds Member Number, if applicable:

Billing Address—indicate "same" if identical to Practice Address.

16a. Address		
16b. City	16c. State	16d. Zip (9 digits)
17. <input type="checkbox"/> I have completed a form for Electronic Funds Transfer (EFT).		
18. <input type="checkbox"/> I am interested in billing electronically		

NOTICE: Anyone who misrepresents or falsifies essential information to receive payment from Federal funds may upon conviction be subject to fine and imprisonment under applicable Federal laws.

Signature (Provider or Representative and Title)	Date
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Group Provider Enrollment — #10c

For group practice enrollment, please enter the following information for **each professional** who will provide services under the group EIN. Select from the attached list the Provider Type code that most closely describes the service(s) that the professional provides. Attach separate sheet for additional entries if necessary.

Name	SSN #	Prov Type Code	License #/ State	Current Lic# Exp Date	Specialty Code(s)	Certification Exp Date

Please return this completed form to the appropriate program at the following address to prevent a delay in the processing of your bills.

<i>For Federal Employees' Compensation Act (FECA) Program:</i>	<i>For Black Lung Program:</i>	<i>For Energy Program:</i>	<i>For Longshore Program:</i>
ACS P.O. Box 14600 Tallahassee FL 32137-4600	DOL Black Lung Program P.O. Box 13200 Tallahassee FL 32317-3200	DOL Energy Program P.O. Box 13400 Tallahassee FL 32317-3400	Division of Longshore and Harbor Workers' Compensation 200 Constitution Avenue, Room C-4315 Washington, D.C. 20210
If you have any questions regarding the completion of the form, please call Toll Free: 1-866-335-8319	If you have any questions regarding the completion of the form, please call Toll Free: 1-800-638-7072	If you have any questions regarding the completion of the form, please call Toll Free: 1-866-272-2682	If you have any questions regarding the completion of the form, please call; 1-202-693-0925

Privacy Act Statement

(1) Collection of this information is authorized by the Federal Employees' Compensation Act (20 CFR 10.801), the Black Lung Benefits Act (20 CFR 725.704 and 725.705), the Energy Employees Occupational Illness Compensation Program Act of 2000 (20 CFR 30.701), and the Longshore and Harbor Workers' Compensation Act (20 CFR 702.503). (2) The information collected on this form will be used to ensure accurate medical provider information for payment of medical and vocational rehabilitation bills. (3) Disclosure of your Social Security Number and completion of this form is voluntary; however, failure to provide the information may result in bill payment delays. (4) This information may be furnished to data processing contractors, to the Department of Labor and to the IRS in accordance with law. (5) Furnishing all requested information will facilitate accurate and timely payment for services to the provider.

Public Burden Statement

We estimate that it will take an average of 8 minutes to complete this information collection, including time for reviewing the instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the information. If you have any comments regarding these estimates or any other aspect of this collection, including suggestions for reducing this burden, send them to the U.S. Department of Labor, Office of Workers' Compensation Programs, Room S-3524, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

DO NOT SEND THE COMPLETED FORM TO THE ABOVE ADDRESS